

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68647

8666

## CERTIFICATE OF DEATH

Reg. Dist. No. 221

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia b. COUNTY Rohr Maryland St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 13 hours		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park Spencer	
d. NAME OF HOSPITAL OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland		d. STREET ADDRESS 169 Prospect Street REF #1, Box 387	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Olive First Middle Last ALLEN		4. DATE OF DEATH Month Day Year August 9 1956	
5. SEX Female 6. COLOR OR RACE Cauc 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 8 Aug. 1956		9. AGE (In years lost birthday) yrs. 12 Months Days 12 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William G. ALLEN		14. MOTHER'S MAIDEN NAME Alma Jane SAUNDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No 16. SOCIAL SECURITY NO. None 17. INFORMANT		Station Hospital, USNAS U.S. Navy Records Patuxent River, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Premature Birth, Neonatal death DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 13 hrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Aug 1956 to 9 Aug 1956, that I last saw the deceased alive on 9 August 1956, and that death occurred at 10:00AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J. E. WOOLEY M.D. MC USNR		M.D. Station Hospital, USNAS, 8-9-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 11/56		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CEMETORY Edinger Cemetery	
22d. LOCATION (City, town, or county) Great Mills, St. Marys, Md. (State)		22e. LOCATION (City, town, or county) Great Mills, St. Marys, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Cheplin Hopkins, A.D., Patuxent River		24a. REC'D BY REGISTRAR ADDRESS DATE 8/14/56	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA  
CERTIFICATE OF DEATH

BUREAU V. ■

103 12 1956

DEPARTMENT OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8667

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Joseph</b>	Middle <b>Alan</b>	4. DATE OF DEATH <b>Aug. 9, 1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1956</b>
9. AGE (In years lost birthday) yrs. <b>11</b>	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Ball</b>		14. MOTHER'S MAIDEN NAME <b>Ann C. Redman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Ann C. Redman</b>		Address <b>Piney Point, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Bronchitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			
491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Mongolism</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 24, 1956</b> , to <b>Aug 9, 1956</b> , that I last saw the deceased alive on <b>Aug 8, 1956</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park Md.</b> DATE SIGNED <b>Aug 10, 1956</b>	
PHYSICIAN'S NAME (Type) <b>William H. Patrick M.D.</b>		323 Midway Drive Lexington Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/56</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St George's</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		24a. REC'D. BY REGISTRAR DATE <b>8/10/56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred J. Hauser</b>	

AMERICAN STATE COMPANIES OF HARTFORD - CONNECTICUT  
CERTIFICATE OF DEATH

BUREAU V. S.

AUG 12 1956

RECEIVED

~~TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.~~

~~TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.~~

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8668

68649

Reg. Dist. No. 282

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>TEXAS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EL PASO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>78 ST. MARYS HOSPITAL</b>		d. STREET ADDRESS <b>1407 Golden Hill Terr.</b>	
3. NAME OF DECEASED (Type or print) <b>EMILY</b>		First <b>MAUDE</b>	Middle <b>BERNARD</b>
4. DATE OF DEATH <b>AUGUST 8 1956</b>	Month <b>AUGUST</b>	Day <b>8</b>	Year <b>1956</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>OCTOBER 11, 1897</b>
9. AGE (In years lost birthday) <b>58</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. FATHER'S NAME <b>WILLIAM LISSAMAN</b>	14. MOTHER'S MOTHER'S NAME <b>MARTHA CROMPTON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>JACK E. PALMER - US NAS PATUXENT RIVER, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Heart failure</i> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <i>Hypertension - Renal Disease</i> <b>DUE TO</b> <b>(c)</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>			
19. WAS AUTOPSY PERFORMED? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2145 1/4 MILE</b>
(County) <b>LEXINGTON PARK</b>		(State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>July 30, 1956</b> to <b>Aug 8, 1956</b> that I last saw the deceased alive on <b>Aug 8, 1956</b> , and that death occurred at <b>2145 1/4 MILE</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Patrick</b>		ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. H. PATRICK, M.D.</b>		DATE SIGNED <b>8-8-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/9/56</b>	22c. NAME OF CEMETERY OR CEMETORY <b>FORT BLISS NATIONAL CEM.</b>	22d. LOCATION (City, town, or county) <b>EL PASO, TEXAS</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. B. Robinson</b>	ADDRESS <b>LEONARDTOWN, Md.</b>	24a. REC'D. BY REGISTRAR <b>8/9/56</b>	24b. REGISTRAR'S SIGNATURE <b>Adams, Housey</b>

CERTIFICATE OF DEATH

RECEIVED  
BUREAU Y. 8  
AUG 10 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8669

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

18650  
282

1. PLACE OF DEATH a. COUNTY ST MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE CALIFORNIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK		b. COUNTY LOS ANGELES	
c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VAN NUYS	
d. NAME OF HOSPITAL OR INSTITUTION STATION HOSPITAL U. S. NAVAL AIR STATION		d. STREET ADDRESS 14904 HAMLIN STREET	
3. NAME OF DECEASED (Type or print) JAMES PATRICK CRONIN		Lost	4. DATE OF DEATH Month Day Year AUGUST 19 1956
5. SEX MALE		6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5/2/1898		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN S. CRONIN		14. MOTHER'S MAIDEN NAME ANNA M. WHELAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT JAMES F. RUMSEY		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		LCDR USN CEREBRAL VASCULAR ACCIDENT INTERVAL BETWEEN ONSET AND DEATH 19hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/18/56, 19, to 8/19/56, 1956, that I last saw the deceased alive on 8/19/1956, and that death occurred at 530 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Station Hospital, U.S. 8/19/56 Naval Air Station Patuxent River, Maryland	
ACTUAL SIGNATURE J. E. SZAKACS LT MC USNR		DATE SIGNED 8/19/56	
PHYSICIAN'S NAME (Type)		22d. BURIAL, CREMATION, REMOVAL (Specify) Transportation 8/21/56	
22b. DATE THEREOF 8/21/56		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Leonardtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		24a. REC'D. BY REGISTRAR DATE 8/20/56	
		24b. REGISTRAR'S SIGNATURE Alfred D. House Jr.	

CERTIFICATE OF DEATH

SUREAU V. S.

AUG 21 1956

RECEIVED

18651  
Reg. Dist. No. 282

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8670 CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood		c. LENGTH OF STAY IN lb 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushwood				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alexander		First	Middle	Last	4. DATE OF DEATH Downs	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 27, 1872	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Downs		14. MOTHER'S MAIDEN NAME Dorsha Redman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.0		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO <i>420.0</i> 10 min</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>arteritis sclerotic</i> DUE TO <i>5 year</i> (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from <i>Jan 15 1959</i> to <i>Aug 3 1959</i>, that I last saw the deceased alive on <i>Aug 3 1959</i>, and that death occurred at <i>7:00 PM</i>, from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <i>Wm D. Boyd</i> M.D.</p> <p>PHYSICIAN'S NAME (Type) <i>WILLIAM D. BOYD</i> M.D.</p> <p>ADDRESS (Street, city or town, state) <i>Leonardtown Md</i></p> <p>DATE SIGNED <i>8/4/59</i></p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 56		22c. NAME OF CEMETERY OR CREMATORIAL Our Lady's		22d. LOCATION (City, town, or county) Medley's Neck		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley.		ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE <i>8/6/56</i>		24b. REGISTRAR'S SIGNATURE <i>Glen A. Hauser</i>		

DEPARTMENT OF HOMELAND SECURITY  
FEDERAL BUREAU OF INVESTIGATION

BUREAU U. S.

AUG 8 1956

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8671

## CERTIFICATE OF DEATH

08652282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN 1b <b>ST. MARYS HOSPITAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. MARYS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NANNIE</b>		First <b>CANE</b>	Middle <b>GOUGH</b>
4. DATE OF DEATH <b>AUGUST 24</b>		Month <b>Day</b>	Year <b>1956</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	B. DATE OF BIRTH <b>16 MAY 1883</b>
8. AGE (In years last birthday) <b>73 yrs</b>		9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CHARLES SMITH</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZA FRAZIER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>MARY B. HEWLETT - SCOTLAND, Md.</b>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 day.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 24, 1956</b> to <b>Aug 24, 1956</b> , that I last saw the deceased alive on <b>Aug 24, 1956</b> , and that death occurred at <b>8-55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm D. B. yd</i>	M.D.	ADDRESS (Street, city or town, state) <i>Leonardtown</i>	DATE SIGNED <b>8/28/56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/27/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>ST. LUKES CEMETERY</b>
22d. LOCATION (City, town, or county) <b>SCOTLAND, MARYLAND</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. B. Robinson</i>		ADDRESS <b>LEONARDTOWN, Md.</b>	24a. REC'D. BY REGISTRAR <b>8/28/56</b>
			24b. REGISTRAR'S SIGNATURE <i>Alma B. Housley</i>

REGEV FFC

AUG 29 1956

BUREAU X-8



RECEIVED  
MAY 5 1956

BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8673

## CERTIFICATE OF DEATH

88654

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Compton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Hervey	Middle S.	4. DATE OF DEATH Knight Jr.	Month August	Day 24,	Year 1956

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 19, 1905	9. AGE (In years last birthday) 50 yrs	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 3	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPH		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington D.C.			

13. FATHER'S NAME Hervey S. Knight	14. MOTHER'S MAIDEN NAME Annie Wilson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 322-05-3396	17. INFORMANT Anita D. Knight	Address Compton, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Heart failure	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	Penitomitis, diffuse, pernicious Caladeno) Colon and on all sites	
(b)		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from <u>Aug 20</u> , 1956 to <u>Aug 24</u> , 1956 that I last saw the deceased alive on <u>Aug 23</u> , 1956, and that death occurred at <u>130</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Leonardtown, Maryland</u>	DATE SIGNED <u>Aug 24, 1956</u>
ACTUAL SIGNATURE <u>Michael Barbarich</u>	M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/27/56	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill	22d. LOCATION (City, town, or county) Washington, D.C.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly	ADDRESS 131 11th St. S.E. Washington, D.C.	24a. REC'D BY REGISTRAR DATE 8/24/56	24b. REGISTRAR'S SIGNATURE <u>Glen L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. /Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31. 10. 1971

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8674

## CERTIFICATE OF DEATH

88655

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Kincaid	Last Lee	4. DATE OF DEATH Aug 15 1956	Month Aug	Day 15	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6 1866	9. AGE (In years last birthday) 90 yrs	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 9	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & sawyer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Sawmill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William T. Lee		14. MOTHER'S MAIDEN NAME Margaret Kincaid		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edward N. Lee		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		INTERVAL BETWEEN ONSET AND DEATH 70 yrs
20c. TIME OF INJURY Hour a. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 9, 1956, to Aug 15, 1956, that I last saw the deceased alive on Aug 13, 1956, and that death occurred at 21 M, from the causes and on the date stated above ACTUAL SIGNATURE J. Roy Guyther M.D.		ADDRESS (Street, city or town, state) Mechanicsville		DATE SIGNED				
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/1956		22c. NAME OF CEMETERY OR CREMATORIUM Jerusalem Christian		22d. LOCATION (City, town, or county) Bel Air		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 8/17/56		24b. REGISTRAR'S SIGNATURE John J. Hanvey		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DECEMBER

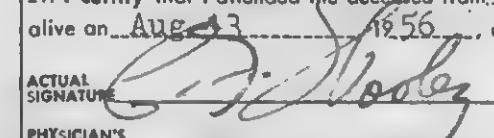
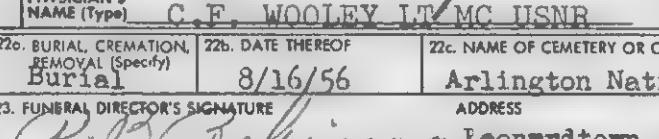
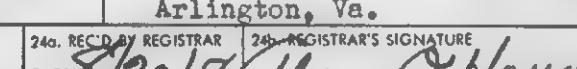
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8675

## CERTIFICATE OF DEATH

108656

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, Patuxent River		c. LENGTH OF STAY IN 1b 2 yr 8 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		d. STREET ADDRESS 903C MOQ, USNAS		
d. NAME OF HOSPITAL OR INSTITUTION Station Hospital, USNAS, Patuxent River, Maryland						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH August 13	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-22		9. AGE (In years lost birthday) 34 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Gates, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Rev. John Oglesby LONG Sr.		14. MOTHER'S MAIDEN NAME Hortense Duncan						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 1943 till present		17. INFORMANT U.S. Navy Records		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Aircraft crashed into water from low altitude						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1000 pm Aug 13 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Air Station Patuxent River, Maryland		20f. CITY OR TOWN Causes State		
21. I certify that I attended the deceased from Aug 13 1956, to Aug 13 1956, that I last saw the deceased alive on Aug 13 1956, and that death occurred at 1001 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE 						DATE SIGNED		
PHYSICIAN'S NAME (Type) C. F. WOOLEY LT MC USNR		M.D. Station Hospital, U.S. Naval 8-13-56 Air Station Patuxent River, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Leonardtown, Md.		24a. REC'D. BY REGISTRAR DATE 8/20/56		24b. REGISTRAR'S SIGNATURE 		

TEAU Y. S.

AUG 21 1960

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18657

8676

## CERTIFICATE OF DEATH

Reg. Dist. No. 281

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		b. COUNTY St. Mary's	
c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Vincent Last McGee		4. DATE OF DEATH August 20, 1956	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 22 1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie McGee		14. MOTHER'S MAIDEN NAME Emily Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Nettie Joy		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concremata of prostate</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1 1956</i> to <i>Aug 20 1956</i> , that I last saw the deceased alive on <i>Aug 20 1956</i> , and that death occurred at <i>470 P St</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Great Mills Md</i> DATE SIGNED <i>21/2/56</i>	
ACTUAL SIGNATURE <i>P. J. Bear</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL St John's		22d. LOCATION (City, town, or county) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE <i>3/21/56</i>	
		24b. REGISTRAR'S SIGNATURE <i>Local Registrar</i>	

BUREAU V. S

AUG 21 1960

REGULATIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8677

## CERTIFICATE OF DEATH

18658  
781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE Md		If institution: Residence before admission b. COUNTY Charles		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 43		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Hughesville (Rural)		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hosp						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Fanny Pearl		First	Middle	Last	4. DATE OF DEATH MORAN	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1907	9. AGE (In years last birthday) 48	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Scott		14. MOTHER'S MAIDEN NAME William Scott Goldie						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO none		17. INFORMANT Joseph A. Moran		Address Hughesville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 74X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		74X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Generalized metastasis from carcinoma - uteri		INTERVAL BETWEEN ONSET AND DEATH 18 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville		(County) (State)
21. I certify that I attended the deceased from Aug 10, 1956, to Aug 14, 1956, that I last saw the deceased alive on Aug 13, 1956, and that death occurred at 4 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) J. Ray Grythe M.D.						ADDRESS (Street, city or town, state) Mechanicsville, Md		DATE SIGNED 8/14/56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-56		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		22d. LOCATION (City, town, or county) Bryantown, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Dr. Land, Hunt		

BUREAU V.

MR 20 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										68659					
8678 CERTIFICATE OF DEATH										Reg. Dist. No. 282					
1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY St Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bushwood			c. LENGTH OF STAY IN 1b 46 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bushwood			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION															
3. NAME OF DECEASED (Type or print) Catherine First L. Middle Reeves					4. DATE OF DEATH August 13, 1956			Month		Day		Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21, 1872		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 9		11. IF UNDER 24 HRS. Days 23 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife					10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME John B. Lyon					14. MOTHER'S MAIDEN NAME Liza Hayden										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. No			17. INFORMANT Thomas B. Reeves			Address Bushwood, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 402.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cause (c)					ARTEROSCLEROTIC CARDIO VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) Compton, Maryland		(County)		(State)	
21. I certify that I attended the deceased from <u>May 15, 1953</u> to <u>Aug 13, 1956</u> , that I last saw the deceased alive on <u>Aug 12, 1956</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.					ADDRESS (Street, city or town, state) Compton, Maryland										
ACTUAL SIGNATURE JOSEPH E. GILL		M.D.		DATE SIGNED 8/16/56											
PHYSICIAN'S NAME (Type) Joseph E. Gill, M.D.		22d. LOCATION (City, town, or county) Chaptico, Maryland													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56		22c. NAME OF CEMETERY OR CREMATORIAL Christ Church		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				ADDRESS				24a. REC'D. BY REGISTRAR DATE 8/16/56		24b. REGISTRAR'S SIGNATURE Glen D. Hauser					

BUREAU V. E. F. E.

1956 17 May

BUREAU V. E. F. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be referred to the hospital or attending physician  
 OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 68660  
 8679 CERTIFICATE OF DEATH 282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARYS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE	
3. NAME OF DECEASED (Type or print) JOHN EDWARD REID		d. STREET ADDRESS RURAL	
4. DATE OF DEATH AUGUST 27 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE COLORED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 7, 1912	
9. AGE (In years lost birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORGAN REID		14. MOTHER'S MAIDEN NAME MILINDA GOLDRING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT NO		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Septicemia abcess teeth. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. st. Aug 27 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) RIDGE, MARYLAND	
(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 26, 1956</u> to <u>Aug 27, 1956</u> that I last saw the deceased alive on <u>Aug 27, 1956</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Leonardtown Md.	
ACTUAL SIGNATURE CHARLES GREENWELL, M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		LEONARDTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/30/56	
22c. NAME OF CEMETERY OR CREMATORIUM ST. PETERS CEMETERY		22d. LOCATION (City, town, or county) RIDGE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE O. B. Johnson		24a. REC'D BY REGISTRAR DATE 8/28/56	
ADDRESS LEONARDTOWN, Md.		24b. REGISTRAR'S SIGNATURE Glen D. Hauser, Jr.	

AUG 30 1964

SEARCHED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8680 CERTIFICATE OF DEATH**

Reg. Dist. No.

18661  
287

1. PLACE OF DEATH a. COUNTY <b>St Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Compton</b>		c. LENGTH OF STAY IN lb <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>343 South Newkirk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Norman</b>	Middle <b>George</b>	Last <b>Schaller</b>	4. DATE OF DEATH	Month <b>Aug.</b>	Day <b>6</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 18, 1894</b>	9. AGE (In years last birthday) <b>62</b> yrs	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles E. Schaller</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Schaller 343 S. Newkirk Street</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Acute coronary insufficiency		Baltimore, Md.		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
		Coronary insufficiency				1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL RE <b>Joseph E. Gill, M.D.</b>		ADDRESS (Street, city, or town, state) <b>Compton, Md.</b> DATE SIGNED <b>8/6/56</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wendell J. Dippell 312 S. Highland Avenue</b>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/10/56</b>		24b. REGISTRAR'S SIGNATURE <b>Alex Houser</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

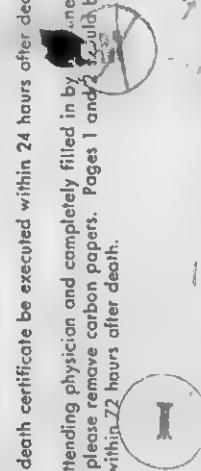
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BUREAU V. S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18662

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## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. MARY'S HOSPITAL			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle SYLVESTER	Last TENNYSON	4. DATE OF DEATH AUGUST 22	Month Day Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 28, 1881	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 6 Days 25 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None	17. INFORMANT George S. Tennyson	Address Avenue, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 134. d Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Eclampsia of lungs (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 11, 1956, to Aug. 22, 1956, that I last saw the deceased alive on Aug. 22, 1956, and that death occurred at 4:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown Md. DATE SIGNED ACTUAL SIGNATURE Charles Greenwell M.D.					
PHYSICIAN'S NAME (Type) CHARLES GREENWELL, M.D.		I. LEONARDTOWN		MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/25/56	22c. NAME OF CEMETERY OR CREMATORIAL St Joseph's	22d. LOCATION (City, town, or county) Morganza,	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			24a. REC'D BY REGISTRAR DATE 8/24/56	24b. REGISTRAR'S SIGNATURE Glen D. Slamer	

8. A. 11. 1988

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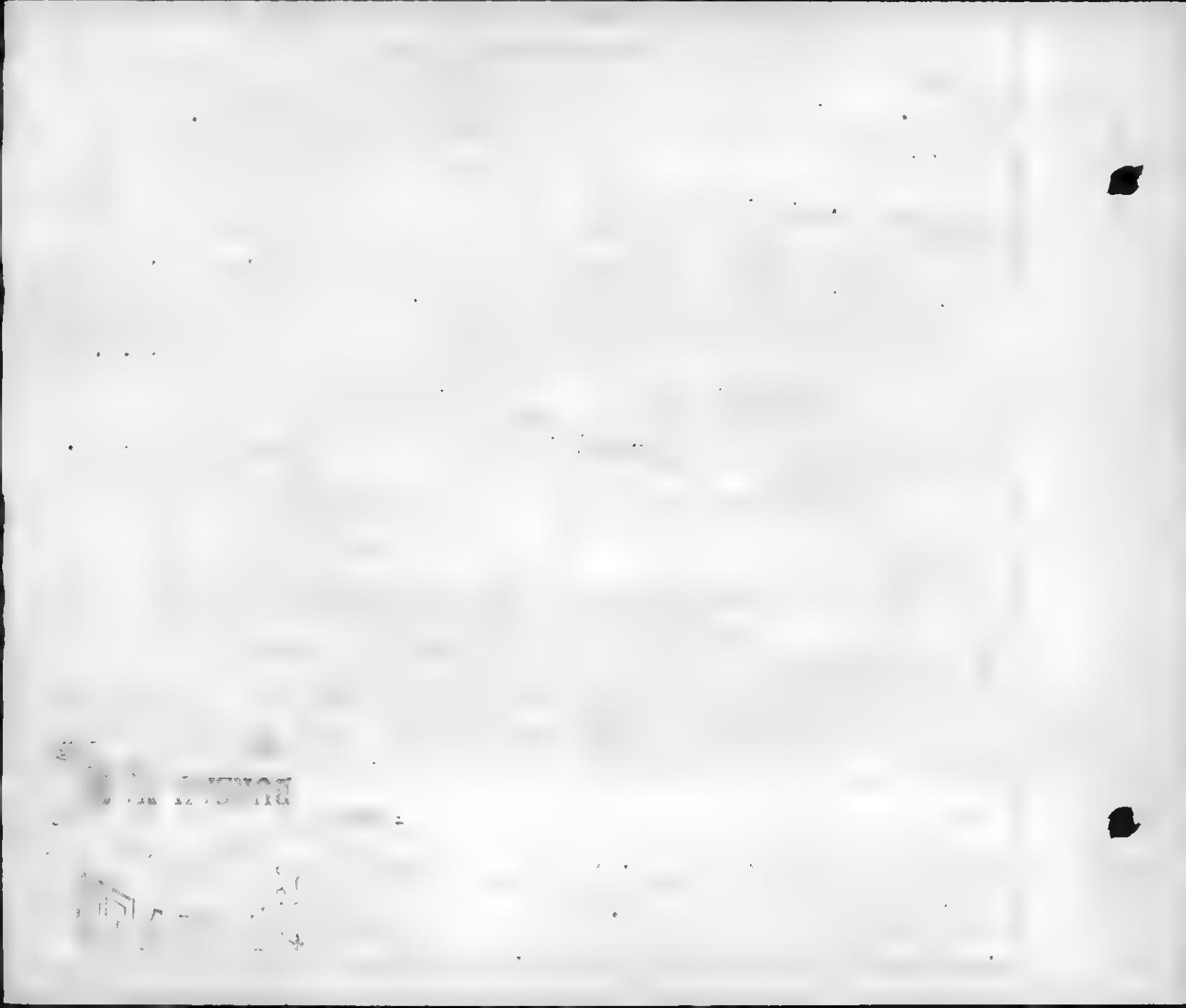


18663  
252

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8682 CERTIFICATE OF DEATH**

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>37 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Joseph</u>	Middle <u>Leo</u>	Last <u>Vallandingham</u>
4. DATE OF DEATH	Month <u>Aug.</u>	Month <u>7,</u>	Day <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1884</u>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years 1st <u>72</u> day yrs)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo Vallandingham</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Bailey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-1194</u>	
17. INFORMANT <u>Mrs Addie Vallandingham Clements, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. <u>11</u> p. <u>19</u>	Month <u>Aug.</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Leonardtown, Maryland</u>
20f. (City or town) <u>Leonardtown</u>	(County) <u>Maryland</u>	(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Aug. 4, 1956</u> to <u>Aug. 7, 1956</u> , that I last saw the deceased alive on <u>Aug. 4, 1956</u> , and that death occurred at <u>1146 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. D. Boyd</u>	M.D.	ADDRESS (Street, city or town, state) <u>Leonardtown, Maryland</u>	DATE SIGNED <u>Aug. 7, 1956</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/56</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>St. Mary's</u>
22d. LOCATION (City, town, or county) <u>Annapolis, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Md.</u>		24a. REC'D. BY REGISTRAR <u>Aug. 10/56</u>	24b. REGISTRAR'S SIGNATURE <u>Glenda D. Hauser</u>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68664

## 8683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 281

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ST. MARY'S		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VALLEY LEE		c. LENGTH OF STAY IN 1b LIFE		a. STATE MARYLAND b. COUNTY ST. MARY'S	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS VALLEY LEE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print) JOHN R. WATTS		4. DATE OF DEATH AUGUST 26 1956		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JULY 27, 1909	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LABOR		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WALTER WATTS		14. MOTHER'S MAIDEN NAME MARY BENNETT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW2		16. SOCIAL SECURITY NO. 578-18-0301		17. INFORMANT Mrs. Lillian Brown, Valley Lee, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>957.8</u> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  <u>Psychotic</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  <u>Fell in stream of water 1/2 mile from Valley Lee Md</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. Aug 26 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near Valley Lee St Mary Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>P. J. BEAN M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/1956		22c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE'S	
22d. LOCATION (City, town, or county) VALLEY LEE, MARYLAND		23. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY, LEONARDTOWN, MD.			
24a. REC'D BY REGISTRAR 172766		24b. REGISTRAR'S SIGNATURE John W. Mattingley Local Registrar			

BURLAHL V. S.

1956

150-1956

## 1 868 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68665

Item 8, Film G201, 8/23/56 bh CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hermanville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Mary's Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Daniel Lee Woods		4. DATE OF DEATH August 12, 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 28, 1956
9. AGE (in years lost birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Day Hours
13. FATHER'S NAME Elbert Woods	14. MOTHER'S MAIDEN NAME Mary D. Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO. Elbert Woods	
17. INFORMANT Elbert Woods		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO and malnutrition (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 7, 1956, to Aug 12, 1956, that I last saw the deceased alive on Aug 11, 1956, and that death occurred at 7A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE P. J. Bean M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/56	
22c. NAME OF CEMETERY OR CEMETORY St Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 8/12/56	
24b. REGISTRAR'S SIGNATURE John B. Begley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 18 Film 6002 S-14-56 Date 16 Item 10 Film 200 12-12-56 606  
**8685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

18666  
 Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>St Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avenue</b>		c. LENGTH OF STAY IN lb <b>Life</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avenue</b>		
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Lynda</b>		First <b>Lynda</b>	Middle <b>Dianne</b>	
		Last <b>Young</b>	4. DATE OF DEATH Month <b>Aug.</b> Day <b>4,</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>James Edward Young</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Elizabeth Armstrong</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		
		17. INFORMANT <b>James E. Young Avenue, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>456X</b> DUE TO <b>Periarteritis nodosa</b> INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>William Vlavitte</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William Vlavitte</b>	DATE SIGNED <b>Aug 5 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/7/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart</b>	22d. LOCATION (City, town, or county) (State) <b>Busshwood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>8/6/56</b>	24b. REGISTRAR'S SIGNATURE <b>Glenn D. Kassner</b>	

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AUG 8 1956